CHAPTER 13
SECTION 3.4

LABORATORY SERVICES

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I. ISSUE

How are laboratory services to be reimbursed?

II. POLICY

NOTE: The following "Policy" remains in effect until implementation of TRICARE Claimcheck. Upon implementation of TRICARE Claimcheck, and only for claims subject to TRICARE Claimcheck, the appropriate reimbursement methodology will be applied in conjunction with TRICARE Claimcheck auditing guidelines.

A. For purposes of the instructions that follow, a diagnostic laboratory test, whether performed in a physician's office, in an independent laboratory, or in another laboratory, is to be treated by the contractor as a laboratory service. The term, "another laboratory", refers to such examples as a reference laboratory that performs services only for other laboratories, or a hospital laboratory functioning as an independent laboratory. Also, when physicians and approved laboratories perform the same test, whether manually or with automated equipment, the services will be deemed similar and the respective charges of all physicians and approved laboratories for that test must be commingled in the computation of the prevailing charge in the state for the test.

B. Determining Prevailing Charges for Single Laboratory Tests.

1. No distinction should generally be made in determining allowable charges for laboratory services between (a) the sites where the service is performed, i.e., physicians' offices or other laboratories; or (b) the methods of the testing process used, whether manual or automated.

2. Therefore, when only one test is performed for a patient, the prevailing charge for the single laboratory test shall be derived from the charges (weighted by frequency) of both the physicians and other laboratories that perform the test in the state, including tests performed manually or with automated equipment. The automated equipment charges to be used are those for a single test that is not performed as part of a battery of tests. The charges of physicians include charges for tests performed in their own offices as well as charges billed for tests performed by other laboratories. The charges of other laboratories include only those charges billed to the general public but not to physicians.

C. Laboratory Tests Utilizing Automated Equipment.

1. Clinical laboratory tests are covered under TRICARE if they are reasonable and necessary for the diagnosis or treatment of an illness or injury.

In the case of multi-channel automated laboratory determinations, however, the physician is not free to specify those tests the patient needs and there is normally only one charge for the battery of tests. The delivery of the services in this manner generally is much more economical than if the tests are performed individually.

a. Until 1998 the CPT-4 included procedure codes for automated, multichannel tests--codes 80002 - 80019. These codes were used to bill multiple tests and to reimburse them.

b. In 1998 the CPT-4 deleted the codes for automated, multichannel tests, and providers were directed to bill using the Organ or Disease Oriented Panels (codes 80049 - 80092) or individual tests. Although providers are required to bill using the current CPT-4 codes, reimbursement will continue to be based on the multichannel tests using TRICARE-created procedure codes W0002 - W0019 which correlate directly to the deleted automated multichannel test CPT codes. TRICARE Claimcheck is used to rebundle the billed codes and establish the reimbursable codes

2. Where at least one test of an initial automated battery of tests can be reasonably related to a specific complaint or symptom, the allowable charge for the complete initial battery of tests is payable. The charge for an initial battery of tests cannot exceed the total of the allowable charges for all the tests if purchased individually. In arriving at an allowable charge determination, the prevailing charge profile shall reflect only charges for automated batteries of tests and not the charges for the tests when performed individually. Of course when a physician bills separately for individual tests of a battery, no more than the allowable charge for the battery can be allowed.

3. The following list contains some of the tests which can be and are frequently done as groups and combinations on automated multi-channel equipment:

a. Albumin

b. Bilirubin, direct

c. Bilirubin, total

d. Calcium

e. Carbon dioxide content

f. Chlorides

g. Cholesterol

h. Creatinine

i. Globulin

j. Glucose (sugar)

k. Lactic dehydrogenase

l. Phosphatase, alkaline

m. Phosphorus

n. Potassium

o. Protein, total

p. Sodium

q. Transaminase, glutamic oxalacetic (SGOT)

r. Transaminase, glutamic pyruvic (SGPT)

s. Urea nitrogen

t. Uric Acid

4. The costs of a battery of tests is ordinarily so low as compared with the costs of tests performed individually that contractors are not expected to scrutinize bills for such batteries individually with regard to the coverage of the test or utilization aspects of the service. Contractors shall, however, review bills when the cost of the battery is relatively high or when a large volume of continuing batteries of tests raises a question about repeat tests. The charge for the battery of tests must, however, be compared to the allowable charge screens in each instance.

5. When a battery of tests is repeated, only those individual tests in the battery which are required to follow the patient's progress are covered. Follow-up tests performed at a frequency greater than is necessary for the reasonable medical management of the patient's condition would not be covered. Payment is not to exceed the prevailing charge for the individually covered tests whether ordered individually or in a battery of tests. For example, the use of the 12-channel serum chemistry test to determine the blood sugar level in a proven case of diabetes would be unallowable because the results of a blood sugar test performed separately would provide the essential information. Normally, the allowable charge for a blood sugar test would be lower than the allowable charge for the automated battery of tests. In no event, however, may payment for the covered tests exceed the allowable charge for the battery.

6. When no test in an automated battery of tests performed initially or as a follow-up measure can be reasonably related to a specific complaint or symptom, no payment will be allowed for the battery.

D. Physician Billing For Tests Performed By An Independent Laboratory. It is the responsibility of the contractor to determine whether the laboratory services were performed

in the office of the physician or by another laboratory. If they were performed by another laboratory, payment may be made only if the laboratory performed tests in the specialties for which it is certified under the Program. When a laboratory performs a test for which it is certified but the ordering provider bills for the service using modifier -90, the allowable charge shall be based on the prevailing charge for that test in the state where the laboratory test was performed. TRICARE Claimcheck auditing logic is incapable of allowing separate payment for services identified by modifier -90. As a result, such services will be incorrectly denied as incidental. Contractors are to follow the policy in this paragraph and ignore the TRICARE Claimcheck denial. (See Chapter 11, Section 14.1, for additional information regarding TRICARE Claimcheck.)

E. Laboratory Tests Performed and/or Billed Out-of-Area.

1. Providers may utilize a laboratory that is located or has a billing address out-of-area as determined by the beneficiary's address on the claim form. In these instances, the location of the laboratory or its billing office governs the pricing of its procedures and provider authorization status under TRICARE. Out-of-area provider and pricing information will be supplied to the appropriate jurisdictional contractor as described in the OPM Part Two, Chapter 1, Section II.D.

2. In those situations where laboratory work is actually performed by an out-of-area laboratory but is being billed by a provider, the contractor with the provider jurisdiction as determined by the beneficiary's address on the claim form will obtain the TRICARE allowable charges rates from the contractor in whose region the tests were performed.

F. Separate Drawing or Collecting and Handling Charges by Physicians.

1. Separate charges made by physicians for the drawing or collecting and handling of specimens (e.g., drawing a blood sample through venipuncture) may be allowed, with the exception of screening PAP tests. Separate charges for the preparation, handling and collection of the screening cervical PAP test are considered to be an integral part of the routine office examination visit and may not be allowed.

2. As used in the context of this instruction, the "drawing" or "collecting" of a specimen refers to those cases in which the physician or his nurse or other paramedical assistant in his employ personally extracts a specimen from the patient. For example, no allowance should be made for collecting a urine specimen that the patient either brings to the physician's office or produces while in the office. On the other hand, a urine specimen extracted through catheterization would meet the foregoing rule. Similarly, a small amount may be allowed for "handling," but only if the physician actually incurs an expense in preparing and shipping a specimen to a laboratory.

3. The total amount allowed for the combined drawing/collecting/handling services (including materials and supplies used) shall not exceed $7. This nominal amount is deemed to be allowable since paramedical personnel are normally capable of providing, and often do provide, the services. Only a single $7 allowance for drawing or collecting and handling charges may be made even if more than one specimen is drawn or collected from a patient on a given occasion. However, higher amounts may be allowed when appropriate in unusual circumstances such as highly complex collection procedures. (See Chapter 13, Section 4.1.)

G. Referral Laboratory Services.

1. The following guidelines shall be used by contractors in processing claims which involve laboratory tests that have been referred by one independent laboratory to another. For purposes of these instructions, the term, "referring laboratory", means the laboratory that sends a specimen to another laboratory which performs the prescribed test. The latter laboratory is the "reference laboratory".

2. The contractor may allow a referring laboratory up to $7 for the costs it incurs for packaging and shipping a specimen(s) to a reference laboratory, provided it is the customary practice of the referring laboratory and the prevailing practice among other referring laboratories in the state to bill separately for these costs. Either one of the following conditions must be met before such allowances can be paid:

a. If a referring laboratory performs a reasonable and necessary test for which it is certified and also forwards a portion of the specimen to a reference laboratory for the performance of a test which the reference laboratory is certified to perform but which the referring laboratory is not able to perform; or

b. If a referring laboratory forwards a specimen to a reference laboratory for the performance of a test which both laboratories are certified to perform but which the referring laboratory is temporarily unable to perform, e.g., because of a breakdown of equipment.

3. No allowance shall be made for any collection or handling charges where (a) the referring laboratory merely draws or collects a specimen from a patient for a test it is not certified to perform and ships it to a properly certified reference laboratory for testing, and (b) the referring laboratory performs no covered service on a portion of that specimen.

4. In determining the proper program allowances for the laboratory tests when the referring laboratory and the reference laboratory are serviced by different contractors, the instructions in paragraph II.E. above are to be followed.

H. Drawing of Specimen By a Laboratory Technician From a Nursing Home Patient or a Homebound Patient.

1. Except for the services incident to a physician's services performed under his general supervision, a nominal amount may be allowed when an contractor determines it was medically necessary for a laboratory technician to draw a specimen from either a nursing home patient or a homebound patient in connection with a covered laboratory test. The technician must personally draw the specimen from the patient for a laboratory test that is determined to be reasonable and necessary before the technician's service would be payable. Medical necessity would not exist where the technician merely performs a messenger service, such as picking up sputum or urine specimens, or where, in the case of a nursing home patient, a nurse draws the specimen which the technician then transports to the laboratory for testing. (In claims involving patients in skilled nursing facilities, the contractors should presume, absent information to the contrary, that the specimens are collected by nursing personnel, and therefore the laboratory is not to be paid for this service.)

2. Payment for this service shall only be made where it has been the practice among independent laboratories in the locality and the practice of the laboratory performing the test

to make a separate charge when a technician is required to draw the specimen from either a nursing home patient or a homebound patient. If such charges are part of the laboratories billing practices in a state, the contractor shall develop a schedule of allowances for the technician's services.

3. Contractors should consult with local and national associations of independent laboratories to resolve any differences that may arise over this payment method. The amounts allowed may not exceed the following limits:

a. An amount not in excess of $7, may be allowed for a technician's service in drawing a specimen from one patient in a nursing home or from a homebound patient.

b. An amount, not in excess of $5 per patient, may be allowed when a technician draws specimens from more than one patient during the same nursing home visit.

c. In both of the above situations, the amount(s) allowed covers the travel expenses of the technician, as well as the specimen drawing service and the materials and supplies used. Exceptions to this rule may be made by the contractor when it is clearly established that the payment is inequitable in light of the distances the technician must travel to perform the service. In general, independent laboratories in metropolitan and urban areas are able to schedule their nursing home visits to coincide with their routine pickups of specimens from physicians' offices and therefore no mileage or travel charges should be allowed in addition to the above amounts. On the other hand, nursing home patients or homebound patients in rural areas may not be easily accessible to the independent laboratories and the servicing contractors may determine, on an individual consideration basis, that a travel expense allowance (in addition to the nominal allowance for drawing the specimen) would be merited. (See Chapter 13, Section 4.1.)

I. Laboratory "stat" charges. On occasion the results of a laboratory test are needed faster than would be possible under routine processing. An additional amount for such "stat" processing is reimbursable. The contractor is to ensure "stat" processing is justified and process the claim on an individual consideration basis. (See Chapter 13, Section 4.1.)

J. The TRICARE/CHAMPUS national allowable charge system used to reimburse professional services discussed in Chapter 13, Section 1.1, Section 1.2, Section 1.3, and Section 1.5 does not apply to laboratory claims except for those pathology claims having physician involvement and interpretation which are identified in the Chapter 13, Section 1.5, Addendum 1. The above reimbursement guidelines are to be used by the contractors. See Chapter 13, Section 4.4.

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